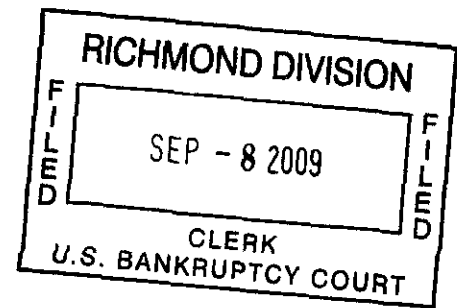


Sept. 1, 2009

Clerk of the Bankruptcy Court
United States Bankruptcy Court
701 East Broad Street -- Room 4000
Richmond, Virginia 23219



Re: Circuit City Stores, Inc
Case No. 08-35653 (KRH)

Dear Clerk,

This letter is in regards to long term disability benefit payments never received by me while I was employed with Circuit City. For my 16 years of employment, I paid into Unum Provident. While I did receive some benefit payments, I was told it was determined I was not disabled enough. In fact, I was sent to a collection agency and ordered to pay back some monies already paid to me.

I have been permanently disabled since May of 2001, and have enclosed documentation providing information regarding this. Why then, was I determined to not be disabled enough by Unum when my cardiologist provided documentation justifying his diagnosis? I was not able to receive any more benefit payments and even worse, asked to pay back part of what was already paid to me. I was so critical, my doctors were not even certain I would survive.

At some point, in the last couple of years, I received a call from Circuit City benefits department stating they were looking further into my benefits package and requested additional information, which I provided.

I am requesting the court look into this matter further, as I feel I was not paid monies owed when first disabled. I understood I would receive \$100.00 per month on permanent disability from my benefits package. There were several years between the start of my disability and Circuit City going out of business.

Respectfully,

Keith Sanders

Keith Sanders
Enclosures

CIRCUIT CITY TM

Circuit City Stores, Inc.
9954 Mayland Drive
Richmond, VA 23233-1464
(804) 527-4000

November 9, 2001

KEITH SANDERS
1391 RALL
CLOVIS CA 93612

Dear KEITH:

At the time your current absence commenced, you were a participant in Circuit City Stores, Inc.'s Group Life Insurance Plan and Long Term Disability ("LTD") Plan.

Under the Group Life Insurance Plan, you had \$25,000 of Basic Life and \$25,000 of Supplemental Life coverage. Under the terms of the Plan, if you become totally and permanently disabled, your life insurance may be continued, subject to the life insurance carrier's approval and age-related reductions, at no cost to you. This benefit must be applied for within 9 months of your first day of absence.

Under the terms of the LTD Plan, benefits may be available to you after 180 days of absence. This benefit must also be applied for no later than 9 months after the date you became disabled. (See page 8 of the enclosed LTD Summary Plan Description for filing after 9 months). If the carrier determines that you have been disabled for 180 days in accordance with the Plan provisions, benefits will commence as of the 181st day of your disability.

To apply for both, continuation of your life insurance and LTD benefits, please complete Section B and sign the Employee's Authorization of the enclosed application. Ask your physician to complete the Attending Physician's Statement of Disability. **This application should be returned to me in the enclosed, self-addressed envelope.** After I receive your completed application, I will complete the Employer's Section and submit it to the carrier. The carrier will review the information and determine if you are eligible for either of these benefits, based on their criteria.

If the carrier determines that you are not disabled in accordance with the Plan provisions, your life insurance coverage will be terminated, and your LTD benefits will cease. If your life insurance coverage is terminated, you may apply to the carrier to convert your Group coverage to an individual policy within 31 days of the date your coverage terminates.

Since your disability has extended beyond five months, you should file for Social Security Disability Benefits. The Social Security Administration has established a toll-free telephone number that may be used nationwide to file applications or make any type of inquiry about Social Security matters. The number is 1-800-772-1213.

Please do not hesitate to contact the STD Specialist at 1-800-288-6353, or the above address, if you have any questions concerning Group Life benefits.

Sincerely,
Benefits Specialist

Enclosure

573847786
ltdsupp1

Uniform -
800-421-0344

HR
TAM
Simpson
7148-
252
JAN 15TH
833-2525
925-847-9201

PATIENT:
D.O.S.:

YOUR PAYMENT OF \$25.00 IS DUE ON 08/15/03.

WE HAVE SUSPENDED ACTIVITY ON THIS MATTER BASED UPON YOUR PROMISE TO
MAKE THIS PAYMENT. UNUM PROVIDENT INSURANCE CO. HAS BEEN NOTIFIED.

YOUR PROMISE HAS BEEN ACCEPTED IN GOOD FAITH, AND WE FULLY EXPECT YOU
TO HONOR YOUR WORD. KINDLY BE CERTAIN THAT THE PAYMENT IS MAILED IN
TIME TO ARRIVE BY THE DUE DATE.

**THIS IS AN ATTEMPT TO COLLECT A DEBT. ANY INFORMATION OBTAINED WILL BE USED
FOR THAT PURPOSE. PLEASE NOTE THAT THIS COMMUNICATION IS FROM A DEBT COLLECTOR.**

NORTH CAROLINA DEPARTMENT OF INSURANCE PERMIT #2094
BUSINESS HOURS: MON-FRI 9AM-5PM

RE: UNUM PROVIDENT INSURANCE CO.

REF: 99132688

TOTAL DUE: \$1,224.54

FOR:

ACCT: 001559516-01-0015

0001192-LET40 0010

LAMONT, HANLEY & ASSOC. INC.

1138 ELM STREET

P O BOX 179

MANCHESTER NH 03105

(800)639-2204



Circuit City Stores, Inc.
5960 Inglewood Drive, Ste. 300
Pleasanton, CA 94588
T 925.847.9201

800 205 6553

February 21, 2002

CERTIFIED

Keith Sanders
1391 Rall
Clovis, Ca 93612

Dear Keith:

The purpose of this letter is to clarify your relationship with Circuit City Stores, Inc.

We are truly sorry about your condition. Considering you have been out of work for more than six months, we regret that we are unable to continue your employment relationship with Circuit City effective with this letter.

As a result of your termination of employment, your participation in any benefit plans in which you were enrolled will also terminate. However, you may choose to continue your Health and Dental coverage, apply for continuation of your Basic and/or Supplemental Life insurance coverage, and apply for Long Term Disability benefits as outlined below.

You may continue your Health and Dental coverage as provided by COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986). If your required contributions are not current, you must make the necessary payments to bring them current before you can continue coverage past [(the end of the month of termination – Insert Date)]. Detailed information about the cost and how to continue coverage will be sent to you within the next couple of weeks.

You may apply for continuation of your Basic and Supplemental Life insurance coverage during your disability. If Great West Insurance Company determines that you are totally and continuously disabled according to their criteria, your coverage will continue, subject to any age-related reductions at no cost to you, as long as you continue to be disabled.

As a participant in our Long Term Disability (LTD) Plan, you may be eligible for LTD benefits. Our benefits department will send the necessary forms to apply for benefits, if you have not already received them.

Since your condition has extended beyond five months, if you have not already done so, you should file for Social Security disability Benefits. The Social Security Administration has established a toll-free telephone number (1-800-772-1213) that may be used nationwide to file applications or make any type of inquiry about Social Security matters.

Should you receive a partial or full release to work from your doctor, you may re-apply for any open position that may be available. Should you be re-hired within a short period of time, you may be eligible for reinstatement.

We appreciate your contribution to the Company and wish you good luck in your future endeavors. If you have any questions concerning your employment or benefits with Circuit City, please contact me at (925) 847-9201.

Sincerely,
Tammy Simpson
Personnel Manager

cc: Location Manager
Personnel File
Margaret Harding, STD Specialist



9954 11/1/01
Richmond, VA 23134-1111
1-800-367-6353

CONFIDENTIAL

November 27, 2002

Mr. KEITH SANDERS
1391 RALL
CLOVIS, CA 93612

ph.
559-292-5334

Re: Vested Benefit from the Retirement Plan of Circuit City Stores, Inc. (the Plan)

Dear Mr. SANDERS:

The following information addresses your vested benefits under the Retirement Plan of Circuit City Stores, Inc. We encourage you to review it thoroughly and, if you are married, share it with your spouse.

According to our records, you are 100% vested in your accrued benefit under the Plan. Your monthly accrued benefit payable for your lifetime only and commencing on your Normal Retirement Date will be \$495.63.

Your accrued benefit was calculated based on the following information. If any of this information is not accurate, please contact us immediately as your monthly benefits may change based on the correct information.

| | |
|-----------------------------------------------|--------------------|
| Date of Birth: | January 5, 1952 |
| Date of Hire: | September 29, 1986 |
| Date of Termination of Employment: | February 21, 2002 |
| Normal Retirement Date: | February 1, 2015 |
| Benefit Service at Termination of Employment: | 15 years |

Generally, the earliest a distribution can be made from the Plan is after a participant reaches Normal or Early Retirement. Early Retirement is at least ten years of Benefit Service at termination of employment and age 55, or at least seven years of Benefit Service at termination of employment and age 62. Benefits can start on the first of any month after meeting these requirements. If benefit payments commence prior to Normal Retirement, they will be reduced to reflect the longer payout period.

If you are eligible for Early Retirement and wish to start your benefits, please send a written request to the Retirement Plan Administrative Committee at the address shown above.

If you die before your Retirement benefits begin and are survived by a spouse, your spouse will be eligible to receive a monthly benefit for his or her lifetime. If you are not married at the time of your death, no benefits would be paid from this Plan.

Benefits are paid only in accordance with Plan provisions, regardless of any written or oral statements you may have received. If any discrepancies exist between this information and the Plan document, the provisions of the Plan document will govern in all instances.

Please keep us informed of your current address. If you have any questions, please contact the Benefits Department at the above address, send an email to retirement@circuitcity.com, or call (800) 288-6353.

Circuit City Stores, Inc.
Retirement Plan Administrative Committee

573-84-7786



Circuit City Stores, Inc.
9954 Mayland Drive
Richmond, VA 23233-1464
T 804.486-4000

CONFIDENTIAL

September 18, 2008

Keith Sanders
5222 N. Hanover Ave
Fresno, CA 93722-6121

RE: Confirmation of Disability Benefits for the Retirement Plan of Circuit City Stores, Inc.

Dear Keith Sanders:

Our records indicate that you terminated employment from Circuit City Stores, Inc. following a disability leave of absence. Under the terms of the Retirement Plan of Circuit City Stores, Inc. ("the Plan"), if you are determined to be Permanently Disabled as of your termination date, 2/21/2002, you may be eligible to receive service for benefit calculation purposes during such period of Permanent Disability, up through February 29, 2008.

An eligible participant will be determined Permanently Disabled and may be credited with additional service under the disability provisions of the Plan if he/she has been determined disabled by the Social Security Administration while employed by the Company and a participant in the Plan.

In order to credit you with the additional service through the Plan Year ending February 29, 2008, we will need you to complete the enclosed Participant Statement of Disability and provide us with a copy of your "Social Security Administration Notice of Award" for your disability. We need to confirm that you were determined Permanently Disabled from 2/21/2002 through each consecutive Plan Year up through February 29, 2008. If you did not keep a copy of the Notice(s), you can provide us with documentation from the Social Security Administration stating the date you were determined disabled, the date disability benefits began, and the disability benefit amount.

In addition, we will need documentation that you received Social Security Disability benefits from the date of the Award through the earlier of February 29, 2008 or the date disability benefits stopped if before February 29, 2008. For example, copies of any **1099 Forms** you have received from the Social Security Administration subsequent to your Notice of Award and/or letters advising you of a change in benefit amount are acceptable. We will use this to determine continued eligibility for disability service.

If you have filed for disability benefits, but have not received a Social Security Notice of Award at this time, please be sure to include the status of your application on the Participant Statement of Disability. As soon as you receive your Notice of Award, either approving or denying benefits, please provide a copy to our office at the address listed below.

We will notify you, in writing, after the Administrative Committee determines your eligibility for continued service. If you do not return the requested information, you will not be credited with any additional service following your termination date.

If you have any questions or concerns regarding the information requested of you, please contact the Associate Service Center at 1-800-288-6353 and select "Retirement" to speak with a Circuit City Pension Helpline representative Monday through Friday, 9:30am to 5:30pm Eastern Time. The mailing address is listed below.

**Circuit City Pension Plan
c/o Mercer
411 E. Wisconsin Avenue
Suite 1500
Milwaukee, WI 53202**

Sincerely,

Retirement Plans Administrative Committee
Circuit City Stores, Inc.
Enclosure



Reassessment Information Form

Mail to: UnumProvident Claim Reassessment Unit

PO Box 9728, Portland, ME 04104-5028

Claim Questions: 1-866-278-4641 Fax to: 1-866-314-1474

REASSESSMENT INFORMATION FORM

Instructions: Please follow the instructions below for each section. The information you provide will assist us in reassessing your claim. If your condition prevents your being able to provide certain information requested, please call 1-866-278-4641 for assistance.

- A. **Claimant Statement:** Provide an update of certain personal information as indicated in this section.
- B. **Employment Statement:** Provide details regarding any work activity from the date your claim was closed through the present. Depending on the terms of your policy, to qualify for benefits you may need to demonstrate a loss of functional duties and/or a loss in income. In order to properly assess your claim we will need to have information regarding all work you have performed. If you are claiming a loss in income while working, provide all supporting documentation available including tax returns and related IRS Forms W-2 and/or 1099; otherwise, this financial information is not needed to reassess your claim.
- C. **Medical Information Details:** Provide all details regarding medical treatment received since your claim was closed. This enables us to obtain any additional medical information we may need from your medical treatment providers. To assist us in the Claim Reassessment Process, enclose any medical records or information you may have in your possession. Medical information after the date your claim was closed is necessary to the extent you are claiming disability beyond the date when your claim was closed.
- D. **Other Income Benefits:** Provide us with details concerning any other income benefits you may have received or are receiving. Please complete this section of the form and attach any supporting information you may have, including benefit awards, summaries etc.

You must sign and date each of the following sections of the form in order for us to begin the Claim Reassessment Process.

- E. **Certification:** Sign and date this form.
- F. **Conditional Waiver and Release:** Sign and date this form.
- G. **Authorization:** Sign and date this form.

Also please enclose any additional information that you feel will assist us in reassessing your claim.

The completed form should be sent to:

UnumProvident
Claim Reassessment Unit
PO Box 9728
Portland, Maine 04104-5028



UNUM.

DISABILITY CLAIM (PLEASE HAVE ALL SECTIONS COMPLETED)

Mail to: Unum, Chattanooga Customer Care Center, P.O. Box 12030, Chattanooga, TN 37401-30;
Claim Questions: 800.633.7479 Fax To: 423.755.3009

A. ATTENDING PHYSICIAN'S STATEMENT (PLEASE PRINT)

1. Name of Patient KEITH ALAN SANDERS Date of Birth 1-5-52 Social Security Number 573-84-7781

2. **Diagnosis** - Please include the primary diagnosis and list any secondary conditions.

Date of Last Examination 1-9-02 Diagnosis (including any complications) include ICD9 and/or DSM IV Multi Evaluation Nomenclature and Code Number CARDIOMYOPATHY 425.4 / ATRIAL FIB 427.31 / CORONARY ARTERY DIS 414.1
Objective findings (including current x-rays, EKGs, psychiatric testing, laboratory data and any clinical findings)

Symptoms

FATIGUE, IRREGULAR HEARTBEAT, LIGHTEADED.

Is this condition due to ☐ an Accident ☐ a Sickness? NO Date symptoms first appeared or accident occurred: 5/23/01

Is the accident or sickness related to the patient's employment? ☐ Yes ☒ No ☐ Unknown

Date restrictions and limitations began: 5/23/01 Has patient ever been treated for the same or similar condition? ☐ Yes ☒ No If yes, state when and describe.

3. Information About the Patient's Ability to Work - this information is critical to understanding your patient's condition

Has patient been released to work in his/her occupation? ☐ Yes ☒ No in any occupation? ☐ Yes ☒ No

If the patient has demonstrated a loss of function, please provide restrictions and limitations and the date they began in the space provided below.

Fully describe restrictions and limitations.

RESTRICTIONS (What the patient should not do) AVOID ANY STRENUOUS ACTIVITY.

LIMITATIONS (What the patient cannot do)

CANNOT WORK 8 HR SHIFT,
CANNOT STAND THROUGHOUT THE DAY.

When should the patient be able to return to work? Full Time:

PERMANENTLY DISABLED.

Part Time:

Height/Weight 5'10" 204 lbs Blood Pressure Last Visit 120/59 If Pregnancy, Expected Delivery Date If Delivered, Actual Delivery Date 2002 FEB 20 Delivery Type ☐ Normal ☐ C-Section

Date of first visit for this illness or injury 5/23/01 Date of next visit 4/9/02 Date of last visit 1/9/02 Frequency of visits MONTHLY

Is patient: ☒ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined Has patient been admitted to hospital? ☐ Yes ☒ No Confined From: 5/23/01 To: 5/25/01

If Hospital Confined, give name and address of hospital FRESNO COMMUNITY HOSPITAL

Have you completed claim forms regarding this patient for other insurance carriers? ☐ Yes ☒ No If yes, state date and name of insurance company:

4. Names and Addresses of Other Treating Physicians

Referring physician or other treating physicians (names, address, phone #'s): DR. ROBERT SUBERS
255 W. BULLARD #109
CLOVIS, CA, 93612
559-299-7294

REQUIRED ATTACHMENTS AND SIGNATURES

Please make sure that office notes, test results, and discharge summaries are attached. This will help reduce additional requests.

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal penalties. This includes Employer and Attending Physician portions of the claim form.

The above statements are true and complete to the best of my knowledge and belief.

Print or Type Name STEPHEN LIPNIK Degree M.D. Medical Specialty CARDIOLOGY
Street Address PO BOX 12334 Phone Number 559 459 3971
City FRESNO State CA. Zip Code 93715 Fax 559 459-6538
Signature of Physician [Signature] Date 1-28-02
SSN or Employer's ID Number: 354-344-6007



May 20, 2002

KEITH SANDERS
1391 RALL
CLOVIS, CA 93612-4521

| | | |
|-----|----------------|-----------------------|
| RE: | Keith Sanders | DOB: January 05, 1952 |
| | Claim Number: | 0099132688 |
| | Policy Number: | 00306136 - 0001 |
| | Tax ID: | 573-84-7786 |

Dear Mr. Sanders:

We are pleased to inform you that your request for disability benefits has been approved. Your first check, in the amount of \$750.00, is for the period of disability from November 19, 2001 through May 18, 2002. This check will be mailed under separate cover directly to you.

As you may know, benefits are not payable during the 180-day elimination period, which extended from May 23, 2001 through November 18, 2001.

This plan provides you with 60% of your basic monthly earnings reduced by certain other income benefits such as Social Security, Workers' Compensation and Pension. Please refer to the monthly benefit reductions in your certificate of insurance for full details.

Monthly benefits are payable on an accrued basis. Every effort will be made to see that future benefit checks are received by you on or before the 20th of the month.

Please read your check copies carefully each month. Messages may appear requesting information from you. We would appreciate your prompt reply to avoid any possible delay in your benefit payment.

We would like to take this opportunity to explain the terms of the contract through your employer. In order to qualify for ongoing benefits, you must continue to meet the definition of disability. We will request that you provide periodic medical evidence and vocational information to support your claim for continued disability benefits.

The policy under which you are covered states:

"You are disabled when UNUM determines that:

UNUMPROVIDENT
Chattanooga Customer Care Center
P.O. Box 12030
Chattanooga, Tennessee 37401-3030
Toll Free 1-800-633-7479
Fax 423-755-3009

UNUMPROVIDENT.



12/27/2002

Circuit City Stores, Inc.
Attn: Employee (LTD) Benefits Administrator
9954 Mayland Drive
Richmond, VA 23233

COPY

Re: Keith Sanders
UNUM Life Insurance Company
Claim No: 0099132688
SSN: 573-84-7786

To Whom It May Concern:

We have completed our review of the appeal of Mr. Sanders's claim and we are writing to inform you that we have upheld our prior decision to terminate his Long Term Disability (LTD) benefits.

The documentation provided for Mr. Sanders's file for appeal did not support restrictions and limitations, which would preclude him from performing the duties of his Own Occupation. Under separate cover, we have provided Mr. Sanders a detailed letter explaining our decision.

We regret that we can not provide you any additional information, as we have not been authorized to release privileged medical information from his LTD claim file.

Please feel free to contact me at 1-800-451-8464, extension 1611, if we may be of further assistance in this matter. I will be happy to assist you.

Sincerely,

Brooke Lewis
Senior Appeals Specialist
Quality Performance Support
UNUM Life Insurance Company of America

IMPORTANT INFORMATION

What If I Work Or Want To Return To Work?

If you receive disability benefits or Supplemental Security Income payments, you must tell us when you have a change in your status that includes becoming disabled or blind again.

Your New Benefit Amount

BENEFICIARY'S NAME:

KEITH A SANDERS

SOCIAL SECURITY CLAIM NUMBER

(only the last 4 digits are shown to help prevent identity theft): XXX-XX-7786 A

Your Social Security benefits will increase by 2.1 percent for 2004, because of a rise in the cost of living. You can use this letter when you need proof of your benefit amount to receive food stamps, rent subsidies, energy assistance, bank loans, or for other business.

How Much Will I Get And When?

- Your new monthly amount (before deductions) is \$1,721.60.
- The amount we are deducting for Medicare is \$66.60.
(If you did not have Medicare as of Nov. 21, 2003, or if someone else pays your premium, we show \$0.00.)
- The amount we are deducting for voluntary federal tax withholding is \$0.00.
(If you did not elect voluntary federal tax withholding as of Nov. 21, 2003, we show \$0.00.)
- After taking any other deductions, we will deposit \$1,655.00 into your bank account on Jan. 14, 2004.

If you disagree with any of these amounts, you should write to us within 60 days from the date you receive this letter.

What If I Have Questions?

We invite you to visit our website at www.socialsecurity.gov on the Internet to find general information about Social Security. You also can call us at 1-800-772-1213, 24 hours a day. We can answer specific questions by phone from 7 a.m. until 7 p.m. on business days. Our lines are busiest early in the week and early in the month so, if your business can wait, it is best to call at other times. Please have your full nine-digit Social Security number available when you call or visit and include it on any letter you send to the Social Security Administration. If you are deaf or hard of hearing, you may call our TTY number, 1-800-325-0778. You also can visit your local office.

5090 N WEST AVENUE
FRESNO CA

BNC #:03B1936D16537

Over →

Your New Benefit Amount

329018

BENEFICIARY'S NAME:

KEITH A SANDERS

Your Social Security benefits will increase by 4.1 percent in 2006, because of a rise in the cost of living. You can use this letter when you need proof of your benefit amount to receive food stamps, rent subsidies, energy assistance, bank loans, or for other business.

How Much Will I Get And When?

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| • Your new monthly amount (before deductions) is | \$1,840.50 |
| • The amount we are deducting for Medicare is (If you did not have Medicare as of Nov. 20, 2005, or if someone else pays your premium, we show \$0.00.) | \$88.50 |
| • The amount we are deducting for voluntary federal tax withholding is (If you did not elect voluntary federal tax withholding as of Nov. 20, 2005, we show \$0.00.) | \$0.00 |
| • After taking any other deductions, we will deposit into your bank account on Jan. 11, 2006. | \$1,752.00 |

If you disagree with any of these amounts, you should write to us within 60 days from the date you receive this letter.

What If I Have Questions?

We invite you to visit our website at www.socialsecurity.gov on the Internet to find general information about Social Security. You also can call us at **1-800-772-1213** and speak to a representative from 7 a.m. until 7 p.m. on business days. If you have a touch-tone phone, recorded information and services are available 24 hours a day. Our lines are busiest early in the week and early in the month so, if your business can wait, it is best to call at other times. If you are deaf or hard of hearing, you may call our TTY number, **1-800-325-0778**. If you are outside the United States, you can contact any U.S. embassy or consulate office, or the Veterans Affairs Regional Office in Manila. Please have your full nine-digit Social Security claim number available when you call or visit and include it on any letter you send to the Social Security Administration. If you are inside the United States, you also can visit your local office.

5090 N WEST AVENUE
FRESNO CA

BNC#: 05B1111E10995

Over ➤

329018*COLA*SM-DI*V05*L007

PRESORTED
FIRST-CLASS MAIL

Your New Benefit Amount

329019

BENEFICIARY'S NAME:

KEITH A SANDERS

Your Social Security benefits will increase by 4.1 percent in 2006, because of a rise in the cost of living. You can use this letter when you need proof of your benefit amount to receive food stamps, rent subsidies, energy assistance, bank loans, or for other business.

How Much Will I Get And When?

- Your new monthly amount (before deductions) is \$1,840.50
- The amount we are deducting for Medicare is \$88.50
(If you did not have Medicare as of Nov. 20, 2005,
or if someone else pays your premium, we show \$0.00.)
- The amount we are deducting for voluntary federal tax withholding is \$0.00
(If you did not elect voluntary federal tax withholding as of
Nov. 20, 2005, we show \$0.00.)
- After taking any other deductions, we will deposit \$1,752.00
into your bank account on Jan. 11, 2006.

If you disagree with any of these amounts, you should write to us within 60 days from the date you receive this letter.

What If I Have Questions?

We invite you to visit our website at www.socialsecurity.gov on the Internet to find general information about Social Security. You also can call us at **1-800-772-1213** and speak to a representative from 7 a.m. until 7 p.m. on business days. If you have a touch-tone phone, recorded information and services are available 24 hours a day. Our lines are busiest early in the week and early in the month so, if your business can wait, it is best to call at other times. If you are deaf or hard of hearing, you may call our TTY number, **1-800-325-0778**. If you are outside the United States, you can contact any U.S. embassy or consulate office, or the Veterans Affairs Regional Office in Manila. Please have your full nine-digit Social Security claim number available when you call or visit and include it on any letter you send to the Social Security Administration. If you are inside the United States, you also can visit your local office.

5090 N WEST AVENUE
FRESNO CA

BNC#: 05B1111E10995

Over ►

329018*COLA*SM-DI*V05*1.007

PRESORTED
FIRST-CLASS MAIL

Your New Benefit Amount

BENEFICIARY'S NAME: KEITH A SANDERS

176932

Your Social Security benefits will increase by 3.3 percent in 2007, because of a rise in the cost of living. You can use this letter when you need proof of your benefit amount to receive food stamps, rent subsidies, energy assistance, bank loans, or for other business.

How Much Will I Get And When?

- Your new monthly amount (before deductions) is \$1,904.50
- The amount we are deducting for Medicare medical insurance is \$93.50
(If you did not have Medicare as of Nov. 15, 2006,
or if someone else pays your premium, we show \$0.00.)
- The amount we are deducting for your Medicare prescription drug plan is \$24.70
(If you did not elect withholding as of Nov. 1, 2006, we show \$0.00.)
- The amount we are deducting for voluntary federal tax withholding is \$0.00
(If you did not elect voluntary federal tax withholding as of
Nov. 15, 2006, we show \$0.00.)
- After taking any other deductions, we will deposit \$1,786.30
into your bank account on Jan. 10, 2007.

If you disagree with any of these amounts, you should write to us within 60 days from the date you receive this letter.

What If I Have Questions?

Visit our website at www.socialsecurity.gov for information about Social Security. Or, call 1-800-772-1213 and speak to a representative from 7 a.m. until 7 p.m. on business days. Recorded information and services are available 24 hours a day. Our lines are busiest early in the week and early in the month; it is best to call at other times. If you are deaf or hard of hearing, call our TTY number, 1-800-325-0778. If you are outside the United States, you can contact any U.S. embassy or consulate office, or the Veterans Affairs Regional Office in Manila. Have your Social Security claim number available when you call or visit and include it on any letter you send to Social Security. If you are inside the United States, you also can visit your local office.

5090 N WEST AVENUE
FRESNO CA

BNC#: 06B1610D06511

Over ➤

SOCIAL SECURITY ADMINISTRATION
OFFICE OF CENTRAL OPERATIONS
1500 WOODLAWN DR
BALTIMORE MD 21241-1500

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE, \$300

**Be sure to check out
our website: www.socialsecurity.gov**

176932*****AUTO** 5-DIGIT 93726
KEITH A SANDERS
APT 102
4949 N WINERY CIRCLE
FRESNO CA 93726-1535

176932*COLA*SM-DI*V04*L009

PRESORTED
FIRST-CLASS MAIL
POSTAGE AND FEES PAID
SOCIAL SECURITY
ADMINISTRATION
PERMIT NO. G-11

LIFT TO OPEN



Your Benefit Amount

Your New Benefit Amount

489767

BENEFICIARY'S NAME: KEITH A SANDERS

Your Social Security benefits will increase by 5.8 percent in 2009 because of a rise in the cost of living. You can use this letter when you need proof of your benefit amount to receive food stamps, rent subsidies, energy assistance, bank loans, or for other business.

How Much Will I Get And When?

| | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| • Your new monthly amount (before deductions) is | \$2,061.40 |
| • The amount we are deducting for Medicare medical insurance is (If you did not have Medicare as of Nov. 20, 2008, or if someone else pays your premium, we show \$0.00.) | \$96.40 |
| • The amount we are deducting for your Medicare prescription drug plan is (If you did not elect withholding as of Nov. 1, 2008, we show \$0.00.) | \$34.40 |
| • The amount we are deducting for voluntary federal tax withholding is (If you did not elect voluntary federal tax withholding as of Nov. 20, 2008, we show \$0.00.) | \$0.00 |
| • After taking any other deductions, we will deposit into your bank account on Jan. 14, 2009. | \$1,930.60 |

If you disagree with any of these amounts, you should write to us within 60 days from the date you receive this letter. We would be happy to review the amounts.

What If I Have Questions?

Visit our website at www.socialsecurity.gov for information and a variety of online services. You can also call 1-800-772-1213 and speak to a representative from 7 a.m. until 7 p.m. Monday through Friday. Recorded information and services are available 24 hours a day. Our lines are busiest early in the week and early in the month; it is best to call at other times. If you are deaf or hard of hearing, call our TTY number, 1-800-325-0778. If you are outside the United States, you can contact any U.S. embassy or consulate office, or the Veterans Affairs Regional Office in Manila. Please have your Social Security claim number available when you call or visit and include it on any letter you send to Social Security. If you are inside the United States, and need assistance of any kind, you also can visit your local office.

5090 N WEST AVENUE
FRESNO CA

BNC#: 08B1936D16537

Over ➤

8/09 Entered 09/09/09 14:28:43 Desc
SOCIAL SECURITY CLAIM NUMBER

KEITH A SANDERS

(only the last 4 digits are shown to help prevent identity theft): XXX-XX-7786 A

How Much Will I Get And When?

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| • Your new monthly amount (before deductions) is | <u>\$1,768.20</u> |
| • The amount we are deducting for Medicare is (If you did not have Medicare as of Nov. 19, 2004, or if someone else pays your premium, we show \$0.00.) | <u>\$78.20</u> |
| • The amount we are deducting for voluntary federal tax withholding is (If you did not elect voluntary federal tax withholding as of Nov. 19, 2004, we show \$0.00.) | <u>\$0.00</u> |
| • After taking any other deductions, we will deposit into your bank account on Jan. 12, 2005. | <u>\$1,690.00</u> |

What If I Have Questions?

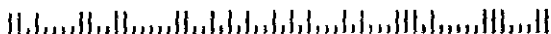
5090 N WEST AVENUE
FRESNO CA

Over ➤

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE, \$300

**Be sure to check out
our website: www.socialsecurity.gov**

319372***** AUTOOCR ** C-013
KEITH A SANDERS
1391 RALL AVE
CLOVIS CA 93612-4521



CIRCUIT CITY®

***Where Service is State of the
Art®***

SUMMARY PLAN DESCRIPTION

LIFE INSURANCE PLAN

P-2084 26 -
6/96

804 527 4068 FAX Award Retirement
JACK Wheeler
Attn Pam Skidmore -

TABLE OF CONTENTS

| | |
|---------------------------------------------------------------------------|----------|
| YOUR LIFE INSURANCE PLAN | 1 |
| WHEN COVERAGE STARTS | 1 |
| ASSOCIATE ELIGIBILITY | 1 |
| REHIRE/REINSTATEMENT | 1 |
| CONTRIBUTIONS..... | 1 |
| ENROLLMENT PROCEDURES..... | 2 |
| PLAN PROVISIONS APPLICABLE TO LATE ENROLLMENT FOR SUPPLEMENTAL LIFE | 2 |
| BASIC AND SUPPLEMENTAL LIFE INSURANCE | 2 |
| BENEFIT SCHEDULE | 2 |
| BENEFIT MAXIMUMS | 3 |
| YOUR BENEFICIARY | 3 |
| CHANGES IN AMOUNT OF LIFE INSURANCE | 3 |
| CONTINUATION OF COVERAGE DURING ABSENCE | 3 |
| IF YOU BECOME TOTALLY AND PERMANENTLY DISABLED..... | 4 |
| CLAIMS | 5 |
| HOW TO FILE LIFE INSURANCE CLAIMS..... | 5 |
| NOTICE OF DENIAL OF CLAIM | 5 |
| APPEAL OF A CLAIM DENIAL..... | 6 |
| DECISION ON REVIEW | 6 |
| WHEN COVERAGE ENDS | 6 |
| CONTINUATION OF LIFE INSURANCE | 6 |
| YOUR RIGHTS UNDER THE PLAN | 7 |
| GENERAL INFORMATION ABOUT THIS PLAN | 8 |

YOUR LIFE INSURANCE PLAN

Circuit City Stores, Inc. offers Regular, Full-time Associates the opportunity to participate in our Basic and Supplemental Life Insurance Plan. Basic Life Insurance, **paid for by the Company**, offers an excellent level of financial security to your family in the event of your death. Associates are automatically enrolled in the Basic Life plan when eligible. Supplemental Life is optional and, if elected, requires a contribution from the Associate. Life Insurance benefits are insured by Great-West Life & Annuity Insurance Company. These benefits are a very important component of our total benefits program. We urge you to read this booklet carefully and share it with your family. Should you have any questions, please contact your Personnel Information Specialist at 1-800-288-6353.

The Plan is comprised of the following benefits:

Basic Life Insurance - Fully paid for by Circuit City Stores, Inc.

Supplemental Life Insurance - Fully paid for by the Associate.

The following information summarizes how the Plan works. In the event of any variation between this booklet and the Group and/or Company Policy, the terms of the Group and/or Company Policy will prevail.

WHEN COVERAGE STARTS

ASSOCIATE ELIGIBILITY

Regular Full-time Hourly, Commissioned, and Salaried I Associates - you are eligible to join the Life Insurance Plan on the *first of the month following six calendar months* of continuous, full-time employment. For example, if you were hired on May 2, your eligibility date would be December 1.

Regular Full-time Salaried II Associates - you are eligible on the *first of the month following one calendar month* of continuous full-time employment. For example, if you were hired on May 2, your eligibility date would be July 1.

Temporary and Part-time Associates are not eligible to join the Plan. If there is a change in your status, eligibility service will be determined in accordance with the Company's Rehire/Reinstatement and Change of Status Policy. Certain Part-time Associates hired prior to June 1, 1993 may be eligible for benefits under this Plan.

REHIRE/REINSTATEMENT

If you terminate employment and are later rehired in accordance with the Rehire/Reinstatement Policy, you will be treated as a new Associate for purposes of this Plan. If you terminate employment and are later reinstated in accordance with the Rehire/Reinstatement Policy, coverage that was in effect at the time of your termination will be reinstated as of the first of the month following your return. If you were not enrolled, you may enroll within 31 days of your reinstate date and benefits are effective the first of the month following your return.

Note: If you are not actively at work due to disability or any other leave of absence on the date your Basic and Supplemental Life Insurance would normally start, coverage will become effective on the first of the month following your return to work, provided you continue to meet the eligibility requirements and have completed the required enrollment form. Being "actively at work" requires that you perform your regular job and work your regularly scheduled hours.

CONTRIBUTIONS

Circuit City Stores, Inc. pays the full cost of Basic Life Insurance. Supplemental Life, if elected, is fully paid for by the Associate. Associate contributions are based on amount of coverage and are made by payroll deduction.

ENROLLMENT PROCEDURES

Eligible Associates must complete the Life Insurance Plan Application/Waiver/Beneficiary Change Form to name a beneficiary for the company-paid Basic Life benefit (see "**Your Beneficiary**" on page 3), and to elect or waive Supplemental Life coverage. If you decline Supplemental Life Insurance when first eligible, you may apply at a later date, subject to Plan provisions (see below "Plan Provision Applicable to Late Enrollment"). The form must be signed to be complete.

Your completed Application/Waiver/Beneficiary Change Form must be received in the Benefits Department in Richmond within 31 days of the date you first become eligible. If it is not received within 31 days, coverage will be delayed and you may be subject to restrictions.

If your first paycheck after the effective date of coverage does not reflect the appropriate payroll deductions for Supplemental Life, contact the Personnel Information Specialist at 1-800-288-6353. If we do not hear from you immediately after you receive your paycheck, coverage will be delayed and you may be subject to restrictions (see below "Plan Provision Applicable to Late Enrollment").

PLAN PROVISION APPLICABLE TO LATE ENROLLMENT FOR SUPPLEMENTAL LIFE

If you do not enroll within 31 days of your initial eligibility date (see page 1) or if you terminate coverage and later wish to re-enroll, you must submit evidence of good health and insurability, at your expense. The insurance company must approve your application before your coverage becomes effective and Great-West can refuse to offer you coverage.

BASIC AND SUPPLEMENTAL LIFE INSURANCE

BENEFIT SCHEDULE

In the event of your death while you are covered, your beneficiary will be paid your Life Insurance Benefit according to the following schedule:

| <u>CLASSIFICATION</u> | <u>BASIC LIFE INSURANCE</u> | <u>SUPPLEMENTAL LIFE INSURANCE</u> |
|-------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| Commissioned Sales Counselors (including CarMax Sales Consultants), Service Technicians and Home Delivery Drivers | \$25,000 | \$25,000 |
| Telemarketing Sales Representatives | \$20,000 | \$20,000 |
| Home Delivery Helpers | \$15,000 | \$15,000 |
| Salaried I, Salaried II and Officers | An amount equal to 2 x your base salary rounded to the nearest \$1,000. | An amount equal to 1 x your base salary rounded to the nearest \$1,000. |
| Hourly Associates | An amount equal to your hourly rate multiplied by 2080, rounded to the nearest \$1,000. | An amount equal to your hourly rate multiplied by 2080, rounded to the nearest \$1,000. |

At age 65, your life insurance is subject to reduction according to the following schedule:

| <u>Age</u> | <u>Percentage of Life Insurance in Effect Immediately Prior to 65th Birthday</u> |
|-------------|--------------------------------------------------------------------------------------|
| 65-69 | 65% |
| 70-74 | 45% |
| 75-79 | 30% |
| 80-84 | 20% |
| 85 and over | 15% |

BENEFIT MAXIMUMS

Benefit maximums are as follows:

| | |
|-------------------|-----------|
| Basic Life | \$400,000 |
| Supplemental Life | \$200,000 |

YOUR BENEFICIARY

You must designate a beneficiary when you complete the Life Insurance Application/Waiver. This designation will apply to your Basic Life and, if elected, Supplemental Life benefits. You may name anyone you wish as your beneficiary. You may name more than one person, and you have the right to change your beneficiary at any time by sending in a new Application/Waiver Form to the Corporate Benefits Department in Richmond. Unless you have specified otherwise, when there are two or more named primary beneficiaries, the benefits will be paid in equal shares.

You may absolutely assign your Life Insurance benefits. The assignment will include your right to the conversion privilege and to change your beneficiary. However, you may not assign your Life Insurance benefit as collateral security.

If you do not name a beneficiary or if your named beneficiaries do not survive you, benefits will be paid in the following order:

- To your surviving spouse; if none, then
- To your surviving child or children in equal shares; if none, then
- To your surviving parent or parents in equal shares; if none, then
- To your surviving siblings in equal shares; if none, then
- To your estate.

CHANGES IN AMOUNT OF LIFE INSURANCE

Changes in life insurance amounts will become effective on the first of the month following the date a change was made that affects your insurance. Your insurance may change as a result of a salary increase or decrease, or a change in status or position. For example, if you receive a salary increase on June 15, your insurance increases as of July 1. If the change results in an increase in benefits, you must be actively at work on the effective date of the change; otherwise, the increase will not be effective until the first of the month after you return to work. If the change results in a decrease in benefits, you may be able to convert up to the amount of coverage lost to a private policy (see "Continuation of Life Insurance" on page 6 for details).

CONTINUATION OF COVERAGE DURING ABSENCES

Disability - In accordance with the Continuation of Benefits policy, benefit coverage will remain in effect during your absence provided required contributions are made. If you receive paychecks during your absence, payroll deductions will remain in effect. If you are not paid during your absence, you are responsible for making your contributions until you return. If you do not pay your share, your coverage may be terminated. If when you return to work you have not made all payments due, payments due will be taken from future paychecks. If your coverage is terminated, you may rejoin the Plan (subject to Plan provisions) upon your return to work.

Leave of Absence: You may continue participation during an approved unpaid Leave of Absence, for up to three (3) calendar months after the month in which the Leave begins, by paying the full cost of such coverage.

Military Service: If you enlist, are inducted or called to military service for active duty, Plan benefits will be determined in accordance with governing laws. Contact the Personnel Information Specialist at 1-800-288-6353 for more information.

Family and Medical Leave: In accordance with the Family and Medical Leave Act of 1993 (FMLA), Circuit City will provide continued life coverage during your absence for any bonafide reason as defined under the Act.

You are responsible for making contributions for your Supplemental Life coverage until you return to work. If you do not pay for Supplemental Life, or if your payment is more than 30 days late, your coverage may be terminated. If when you return to work you have not made all payments due, payments due will be taken from future paychecks. If your coverage is terminated, you will be reinstated upon your return to work with the life benefits you were enrolled in prior to your Family and Medical Leave.

IF YOU BECOME TOTALLY AND PERMANENTLY DISABLED

If you become totally and permanently disabled as the result of an injury or disease while covered under the Basic and/or Supplemental Life Plan, your life insurance will be continued for 12 months from the date your disability commenced. If you are wholly and continuously prevented from engaging in any occupation for which you are qualified, you may apply to continue your life insurance beyond 12 months, subject to approval by the insurance company (at no cost to you). The insurance company will require periodic proof of your disability status.

How to Apply

Basic Life

Complete and submit the Proof of Disability Form which must include medical evidence of your disability. This form is submitted to the insurance company after you have been continuously disabled for nine months, but *no later than the end of the twelfth month of disability*. If the insurance company approves such continuation, your coverage will continue until the earlier of the date you are no longer disabled, or the date you reach age 70.

Supplemental Life

If you elected and had been making payroll contributions for the Supplemental Life Insurance coverage, you may also apply for continuation of Supplemental Life due to total disability. The form and proof of disability referenced above under **Basic Life** also apply to this coverage. If you are approved totally disabled before age 60, your Supplemental Life Insurance continues until the date you are no longer disabled. If your disability begins on or after you reach age 60, your insurance will continue until the **earliest** of:

- (1) the date you are no longer disabled;
- (2) five years after your date of total disability; or
- (3) the date you reach age 70.

Notice of any decision denying the claim must be furnished within 90 days after the claim is filed. If special circumstances require an extension of time to act on the claim, another 90 days will be allowed. If such an extension is required, notification will be given by the Plan Administrator before the end of the initial 90-day period. If the claim is not processed or a notice is not given within these time periods, the claim will be deemed to have been denied for the purpose of proceeding to the claim review procedure described below.

APPEAL OF A CLAIM DENIAL

If there are any questions about a claim payment, the Plan Administrator should be contacted. If you desire to initiate a claim review procedure because there is disagreement with the reasons why the claim was denied, the Plan Administrator should be notified in writing within 60 days after receipt of the written claim denial. A request for a review of the claim and examination of any pertinent documents may be made by the claimant or anyone authorized to act on his or her behalf. The reasons why it is believed that the claim should not have been denied, as well as any data, questions, or appropriate comments, should be submitted in writing.

DECISION ON REVIEW

Notification of the final decision will be given 60 days after receipt of a request for review unless special circumstances, such as a Peer Review Board review of the claim, require an extension of time for processing, in which case another 60 days will be allowed.

WHEN COVERAGE ENDS

Unless otherwise specified in this booklet, coverage under this Plan will end on the earliest of the following:

- The last day of the month in which your employment ends, including termination due to retirement;
- The last day of the month in which you stop being an eligible Associate;
- When you stop making required contributions; or
- When the Plan terminates.

OTHER

Coverage may be terminated for fraud or deception in the use of the services of the Plan or knowingly permitting such fraud or deception by another. Termination for fraud or deception shall be effective upon mailing of written notice to you.

CONTINUATION OF LIFE INSURANCE

If your life insurance terminates due to your termination of employment or any other reason or it is reduced due to a change in salary or age, you may apply for an individual life insurance policy (one of the standard conversion policies offered by Great-West Life) without taking a medical examination. You may convert up to the amount of coverage lost. If you have been insured under this Plan for at least five years, you may also apply for an individual policy if the group policy terminates, or if the Plan is amended to reduce your amount of insurance.

You must apply for an individual policy within 31 days after termination/change in employment status or reduction of your insurance. During this 31-day period, your life insurance remains in force free of charge. If you wish to continue coverage, contact the Benefits Department in the Corporate Office in Richmond (800-288-6353) for an application. Your completed application must be returned to Great-West Life within 31 days of the date of termination/change in employment status or reduction of insurance.

The amount of Basic and Supplemental Life Insurance that may be continued will be that for which you were insured on the date your disability began, subject to the age reductions in effect under this Plan on such date. In the case of a reduction, you may apply for an individual policy (as discussed under "Continuation of Life Insurance"). *If you do not submit the required proof of disability before the end of the twelfth month of disability, or continuation is not approved, your coverage will terminate.*

In any event, after you have been disabled for six months you should contact the Benefits Department at the Corporate Office in Richmond for information about continuation of life insurance.

Accelerated Benefit

If you are terminally ill, you may apply to receive an Accelerated Benefit of up to 50% of the amount of your life insurance, up to a maximum of \$100,000 (the minimum is \$1,000). The Accelerated Benefit will be paid in a lump sum, and will be paid only one time. In order to qualify, you must have a Qualifying Medical Condition, which means you must be terminally ill with a life expectancy of 12 months or less, and provide Great-West with satisfactory proof of the condition. In considering your request for an Accelerated Benefit, Great-West may, at its expense, require that you be examined by a doctor of their choice.

If the amount of your Life Insurance is scheduled to reduce within 36 months of the date you apply for the Accelerated Benefit, as outlined in the age reduction schedule on page 3, then the amount of the Accelerated Benefit will be based on the reduced amount.

If you recover from your Qualifying Medical Condition after receiving an Accelerated Benefit, Great-West will not ask you for a refund of the Accelerated Benefit; however, your amount of life insurance will be reduced by the amount of the Accelerated Benefit.

NOTE THAT ANY ACCELERATED BENEFIT THAT YOU RECEIVE MAY BE TREATED AS TAXABLE INCOME AND MAY AFFECT YOUR ELIGIBILITY FOR MEDICAID OR OTHER GOVERNMENT BENEFITS OR ENTITLEMENTS. YOU SHOULD CONSULT YOUR PERSONAL TAX AND/OR LEGAL ADVISOR BEFORE YOU APPLY FOR AN ACCELERATED BENEFIT.

To apply for an Accelerated Benefit, you or someone with legal authority to act on your behalf should contact the Personnel Information Specialist at 1-800-288-6353 for the appropriate application form, details and limitations.

CLAIMS

HOW TO FILE LIFE INSURANCE CLAIMS

In the event of your death, the Plan Administrator will contact your beneficiary to explain what is required before payment of your life insurance benefit can be made. The Plan Administrator will provide the necessary forms and instructions. If prompt contact is not made by the Plan Administrator, your beneficiary should contact the Plan Administrator.

The life insurance benefit payable on your death will generally be paid to your beneficiary in a lump sum unless, by written notice to the insurance company, you or the beneficiary have requested that it be payable on an installment basis or left on deposit with the insurance company, as provided in the group policy.

NOTICE OF DENIAL OF CLAIM

If any benefits are denied, either in whole or in part, notification of the specific reason for the denial will be given along with reference to the pertinent plan provisions on which the denial is based. Guidance as to any additional material or information required to resubmit the claim will be included.

YOUR RIGHTS UNDER THE PLAN

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misused the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact your Plan Administrator. If you have any questions about this statement, or about your rights under ERISA, you should contact the nearest area office of the U.S. Labor Management Services Administration, Department of Labor.

This booklet is a summary of the principal features of the Plan. Group Policy No. 34308GL issued by Great-West Life, and Circuit City Stores, Inc. policies are the governing documents. In the event of any variation between the information in this summary and the provisions of the policies, the latter will prevail. This Plan is underwritten by Great-West Life & Annuity Insurance Company, Head Office - Winnipeg, Canada. The Policyholder is Circuit City Stores, Inc.

GENERAL INFORMATION ABOUT THIS PLAN

NAME OF THE PLAN: The name of the Plan is the Circuit City Stores, Inc. Associate Life Insurance Plan.

PLAN SPONSOR: Circuit City Stores, Inc.
9950 Mayland Drive
Richmond, Virginia 23233
Telephone: (804) 527-4000

PLAN ADMINISTRATOR: Circuit City Stores, Inc.
9950 Mayland Drive
Richmond, Virginia 23233

PLAN YEAR: The end of the year for purposes of maintaining the Plan's fiscal records is June 30.

FUNDING: The Plan is fully insured by Great-West Life & Annuity Insurance Company and funded by Circuit City Stores and Associates who elect Supplemental Life Insurance.

TYPE OF ADMINISTRATION: Fully insured Group Policy Administration.

AGENT FOR SERVICE OF LEGAL PROCESS: Process may be served by calling (804) 527-4000 or by writing to Circuit City Stores, Inc., 9950 Mayland Drive, Richmond, Virginia 23233, Attention: Corporate Secretary.

IDENTIFICATION NUMBERS: Employer Identification Number (EIN): 54-0493875; Plan Numbers (PN): 501

OTHER: *In the event the relevant facts about your enrollment were inaccurate or administrative errors occur, an adjustment will be made. Additional contributions from you or a refund to you may be required to correct the situation. In any event, the terms of our Group Policy and/or Company policies will prevail.*

The benefits described in this Booklet do not constitute or imply employment contracts or any other contractual obligations between the Company and its Associates and/or other individuals eligible to participate in this Program.

Circuit City Stores, Inc. retains the right to modify or terminate any of these benefits without the consent of or notice to Associates and/or other individuals eligible to participate in this Program. The Company maintains these Programs by choice, not obligation.

Business

THE FRESNO BEE • SUNDAY, DECEMBER 15, 2002

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Insurer faces complaints

Unhappy disability policyholders say UnumProvident puts its profits first.

By MICHAEL LIEDTKE
ASSOCIATED PRESS

SAN FRANCISCO — When the nation's largest disability insurer set out in 1994 to cut its losses from expensive long-term claims, it created a "Hungry Vulture" award to honor its most relentless employees.

The award, handed out by the company that became UnumProvident Corp., bore a ruthless motto: "Patience, my foot ... I'm gonna kill something."

The insurer scrapped the Hungry Vulture several years ago, but hundreds of unhappy policyholders allege the Chattanooga, Tenn.-based company still puts profits before the welfare of seriously ill and badly injured people.

The complaints come from people such as Loreta Hale, a once-successful San Francisco Bay Area real estate broker who has been fighting to collect her disability benefits for the past 5½ years while dying of cancer.

A Contra Costa Superior Court jury re-

turned a \$1.5 million fraud verdict against UnumProvident in July 2000, but the company is pursuing an appeal that may outlive Hale.

"It's a strange feeling knowing someone wants you to die because of money," said Hale, 49.

UnumProvident dismisses most of the allegations as the sour grapes of a relatively few duplicitous and uncooperative policyholders.

The company maintains that customer

complaints have been overblown by opportunistic lawyers and sensational media accounts, including stories on CBS' "60 Minutes" and "Dateline NBC."

"We are 100% proud of our customer care organization," said Thomas White, the company's vice president of corporate relations.

In a September court filing, however, UnumProvident listed more than 2,500 policyholder lawsuits accusing the company of fraud or breach of contract. The suits were filed between January 1997 and August of this year.

Please see **INSURER**, Page C2